NHS Scarborough & Ryedale and Vale of York Clinical Commissioning Groups

Tonsillectomy Commissioning Policy

Intervention	**Tonsillectomy for recurrent tonsillitis in adults and children**
OPCS codes	F34 Excision of tonsil F341 Bilateral dissection tonsillectomy F342 Bilateral guillotine tonsillectomy F343 Bilateral laser tonsillectomy F344 Bilateral excision of tonsil NEC F345 Excision of remnant of tonsil F346 Excision of lingual tonsil F347 Bilateral coblation tonsillectomy F348 Other specified excision of tonsil F349 Unspecified excision of tonsil
For the treatment of:	**Recurrent tonsillitis**
Exclusions to policy	**NHS Scarborough & Ryedale and Vale of York CCGs routinely commission treatment for Red Flag conditions (see clinical management).** Please note this guidance only relates to patients with recurrent tonsillitis. It **does not** apply to other conditions where tonsillectomy should continue to be normally funded, these include : • Obstructive Sleep Apnoea / Sleep disordered breathing in Children • Suspected Cancer (e.g. asymmetry of tonsils) • Recurrent Quinsy (abscess next to tonsil) • Emergency Presentations (e.g. treatment of parapharyngeal abscess) • Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous • Acute and chronic renal disease resulting from acute bacterial tonsillitis • As part of the treatment of severe guttate psoriasis • Metabolic disorders where periods of reduced oral intake could be dangerous to health • PFAPA (Periodic fever, Apthous stomatitis, Pharyntitis, Cervical adenitis)
Commissioning position	**Referral criteria for possible tonsillectomy** The CCGs do not routinely commission tonsillectomy. Tonsillectomy will only be commissioned in accordance with the criteria specified below for recurrent acute sore throat in adults and children in the following circumstances: Sore throats are due to acute tonsillitis where • The episodes are disabling and prevent normal functioning i.e. there has been significant severe impact on quality of life and normal functioning, as indicated by documented objective evidence (e.g. absence from school, failure to thrive) **AND THERE HAS BEEN** • Seven or more, well documented, clinically significant*, adequately treated sore throats in the preceding year **OR** • Five or more well documented, clinically significant*, adequately treated sore throats in each of the preceding two years **OR**

	• Three or more well documented, clinically significant*, adequately treated sore throats in each of the preceding three years. **AND** • There has been a discussion with patient/parents or carers in relation to the benefits and risks of tonsillectomy vs watchful waiting, as emphasised by the Royal College of Surgeons guidance[3]. Information should be provided (see patient leaflet section below) and reassurance given if no further treatment or referral for tonsillectomy is deemed necessary at this stage. This discussion should be documented. *preferably demonstrated by FeverPAIN or Centor scores (see below) The impact of recurrent tonsillitis on a patient's quality of life must be taken into consideration. A fixed number of episodes, as described above, may not be appropriate for adults with severe symptoms and an application can be made to IFR for earlier surgery. Tonsillectomy for the treatment of halitosis associated with tonsillar debris is NOT routinely commissioned. The CCGs will also consider funding via IFR in **children (aged <16) with sleep disordered breathing** if **ANY ONE** of the following applies: • A positive sleep study • Significant impact on quality of life (daytime behaviour/sleepiness) Within secondary care, there should be • Confirmation of primary care assessment, fulfilment of the criteria for tonsillectomy and impact on quality of life and ability to work/attend school • Management options –tonsillectomy, or referral back to primary care for ongoing monitoring **Patients who are not eligible for treatment under this policy can be considered on an individual basis, where their GP or consultant believes exceptional circumstances exist that warrant deviation from this policy.** **Individual cases will be considered by the Individual Funding Request panel.**
Clinical management	**Red flag conditions – consider need for admission or urgent referral[1, 2, 9]** • Epiglottitis • Peritonsillar abscess (quinsy) • Persistent sore throat for > 6 weeks • Current or a history of excessive drooling (inability to swallow saliva) with acute inflammation/infection. • Retropharyngeal abscess which can cause visible neck swelling and trismus (inability to open the mouth) • Unilateral facial swelling • Dysphagia • Dyspnoea • Immunosuppressant medication such as carbimazole • Is immunosuppressed – HIV, steroid use, post-transplant, leukaemia,

asplenia, aplastic anaemia
- Persistent unilateral tonsillar enlargement – consider malignancy
- Signs of Meningitis - Neck stiffness, Photophobia, Non-blanching rash
- Lemierre syndrome — thrombophlebitis of the jugular vein
- Severe oral mucositis
- Adult obstructive sleep apnoea with tonsillar enlargement (if trials of continuous positive airway pressure (CPAP) and the use of mandibular advancement devices are unavailable or unsuccessful).
- Severe neck infection
- Witnessed episodes in children of apnoea exceeding 10 seconds OR choking episodes during sleep
- Patients with sore throat who have stridor, progressive dysphagia, bleeding, increasing pain or severe systemic symptoms (may require hospital admission)
- Tonsil bleeding

Acute Management of Sore Throats

NICE CKS states:

- Studies have shown that use of antibiotics for streptococcal sore throat decrease symptom duration by less than 1 day.
- The threshold for prescribing antibiotics should be lower in people at risk of rheumatic fever (such as people with a previous history of rheumatic fever and those living in South Africa, Australian indigenous communities, Maori communities of New Zealand, the Philippines, and many developing countries), and vulnerable groups of people who are being managed in primary care, (such as infants, very old people, and those who are immunosuppressed or immunocompromised).
- Antibiotics should not be withheld if the person has very severe symptoms and there is concern about their clinical condition.
- For people not in a vulnerable group, and without severe symptoms, or who have a FeverPAIN score of 2 or3 consider a delayed antibiotic prescribing strategy.
- Acute Group A streptococcal (GAS) pharyngitis/tonsillitis is common in children and adolescents aged 5 to 15 years and is more common in the winter (or early spring) in temperate climates. Streptococcal infection is suggested by fever > 38.5°C, exudate on the pharynx/tonsils, anterior neck lymphadenopathy, and absence of cough. A scarlatiniform rash may be present, especially in children."

FeverPAIN score

The FeverPAIN clinical score can help prescribers to determine if a sore throat is more likely to be caused by bacteria. Higher scores suggest more severe symptoms and likely bacterial (streptococcal) cause. Each of the FeverPAIN criteria (below) score 1 point (maximum score of 5).

- Fever
- Purulence
- Attend rapidly (3 days or less)
- Severely Inflamed tonsils
- No cough or coryza

A score of 0 or 1 is associated with a 13% to 18% likelihood of isolating streptococcus. A score of 2 or 3 is associated with a 34% to 40% likelihood of isolating streptococcus. A score of 4 or 5 is associated with a 62% to 65% likelihood of isolating streptococcus

	Centor criteria • Tonsillar exudate • Tender anterior cervical lymphadenopathy or lymphadenitis • History of fever (over 38°C) • Absence of cough Each of the Centor criteria score 1 point (maximum score of 4). A score of 0, 1 or 2 is thought to be associated with a 3 to 17% likelihood of isolating streptococcus. A score of 3 or 4 is thought to be associated with a 32 to 56% likelihood of isolating streptococcus.
Patient Information Leaflets	Adult Tonsil Surgery – from ENT UK – click here Childrens Tonsil Surgery – from ENT UK – click here Tonsillitis – NHS Choices – Patient information on tonsillitis
Summary of evidence / rationale	The literature on surgery for recurrent tonsillitis is limited. Most published studies refer to a paediatric population. The quality of the evidence for tonsillectomy in children is poor, but it suggests that surgery may be beneficial in selected cases. The small amount of information about adult sore throat and the effect of tonsillectomy is not scientifically robust but suggests that surgery can be beneficial for recurrent sore throats. The benefits of surgery compared to non-surgical treatment was the subject of a Cochrane Collaboration review (since updated) which provided additional evidence for the SIGN guidance[4, 5]. The consensus is that these criteria help to identify patients most likely to gain benefit from surgical intervention but the evidence level is low at 3/4 and clinical judgement is needed to identify patients where exceptionality applies. The Cochrane review found no randomised trials in adults and found that the evidence in children was limited by the lack of studies. Two randomised trials were found, but it was not possible to draw conclusions because many of the children also underwent adenoidectomy [Burton and Glasziou, 2009]. The authors of the Scottish Intercollegiate Guidelines Network (SIGN) guidance commented on[5]: 1. Four randomised clinical trials. One trial (which was included in the Cochrane review) found that there was no significant difference between the group that had a tonsillectomy and the group who did not. The other three studies had all taken place before 1972 and no conclusions could be drawn because of methodological flaws. 2. Three additional non-controlled studies. These suggested benefit of tonsillectomy for both reducing the number of sore throats, and improving general health. The evidence on referral criteria for sore throats is based on evidence from a paediatric population. At the time that the referral criteria were written there were no randomised controlled trials concerning the management of recurrent sore throats in adults[3]. A randomised trial in adults (people over 15 years of age) compared tonsillectomy (n = 36) with watchful waiting (n = 34) [Alho et al, 2007]: Criteria for entry to the trial were three or more episodes of pharyngitis in 6 months, or four or more episodes in 12 months.

	The primary end point was the proportion of people with an acute episode of group A streptococcal pharyngitis during the 90 days' follow up, as determined by signs and symptoms of acute pharyngitis and a positive result of throat culture. At 90 days streptococcal pharyngitis had recurred in 24% (8/34) of the control group and in 3% (1/36) of the tonsillectomy group (difference 21%, 95% CI 6 to 36). The number of people needing to undergo tonsillectomy to prevent one recurrence of streptococcal pharyngitis during the few months after tonsillectomy was five (NNT = 5). The authors concluded that tonsillectomy is an effective alternative for adults with a documented history of recurrent episodes of pharyngitis.
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References:

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2. NICE (2005) Referral for suspected cancer (NICE guideline) Clinical guideline 27. National Institute for Health and Clinical Excellence.www.nice.org.uk [Free Full-text]
3. Royal College of Surgeons Commissioning guide: Tonsillectomy Sept 2013
4. Cochrane Review of Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis (Cochrane Review) Nov 2014
5. Scottish Intercollegiate Guideline Network (SIGN) guideline: Management of sore throat and indications for tonsillectomy, a national clinical guideline [SIGN, 2010 report number 117] and the Centor clinical prediction score [Centor et al, 1981; Aalbers et al, 2011; ESCMID Sore Throat Guideline Group et al, 2012].
6. NICE CKS Management of acute sore throat July 2018 (https://cks.nice.org.uk/sore-throat-acute)
7. Royal College of Surgeons. National prospective tonsillectomy audit: final report of an audit carried out in England and Northern Ireland between July 2003 and September 2004. London: Royal College of Surgeons of England; 2005.
8. Burton MJ, Glasziou PP, Burton MJ, Glasziou PP. Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis. [Review] [20 refs][Update of Cochrane Database Syst Rev. 2000;(2):CD001802; PMID: 10796824]. Cochrane Database of Systematic Reviews 2009;(1):CD001802.
9. Red Flag symptoms - https://www.gponline.com/red-flag-symptoms-pharyngitis/ear-nose-and-throat/article/1379827
10. NHSE/NHSI Evidence Based Interventions Policy – published November 2018

Version	Created /actioned by	Nature of Amendment	Approved by	Date
1.0	Lead Clinician and Senior Service Imp Manager	Re-drafting of STP and SR/VoY policies	n/a	
2.0	Senior Service Improvement Manager	Share of new draft internally and circulation for consultation	Lead Clinicians – VoY and SR CCGs	Oct 18
2.1 – 2.5	Senior Service Improvement Manager	Update of statement following comments from consultation	Lead Clinicians – VoY and SR CCGs	Jan 19

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3.0	Senior Service Improvement Manager	Approval by CCG Committees	SRCCG Business Committee VoYCCG Executive Committee	March 19 March 19